

**Remembering our Past,
Building the Future:
100 Years of the Maternal and Child Health
Research Program**

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Abstract

On April 9, 1912, an Act establishing the Children’s Bureau was signed by President William Howard Taft. The original mission of the Children’s Bureau was to “investigate and report ... upon all matters pertaining to the welfare of children and child life among all classes of our people.” This two-part paper provides an overview of the 100-year history and mission of the federal Maternal and Child Health Research program, beginning with its origins in the U.S. Children’s Bureau in 1912 through the present day. Part 1 of the paper covers the period from the founding of the Bureau through the Social Security Act of 1935, with special attention to the ways in which research findings motivated changes in policies and practice. Part 2 covers the years from 1935 through the present day, with special attention to the vision underlying the extramural MCH research program (established in 1963), and the impact of the 1969 reorganization of the Children’s Bureau, which moved the MCH Research Program into the Public Health Services into what is now the Health Resources and Services Administration (HRSA). Discussion focuses on the mission of the MCH Research program, how that has been realized in the past and present, and what we can learn from that for the future.

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**Remembering our Past,
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Research Program
Part 1: 1912-1935**

“Perhaps herein lies the perspective of the past and the forecast for the future: Society moves forward in terms of what its care, hopes, and aspirations are for its children.”

--Katherine B. Oettinger, Fifth Chief of the Children's Bureau, 1960

Roots

Through its 100-year history, the Maternal and Child Health Research Program has served as a focal point in the expression of national concern for children. Currently housed in the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services, the MCH Research Program traces its roots back to 1912 when Public Law (PL) 62-116 established the Children's Bureau under President William Howard Taft.

The creation of the Children's Bureau on April 9, 1912, represented the culmination of over 6 years of effort on the part of determined citizens and child welfare organizations to persuade Congress to establish an agency primarily focused on the health and wellbeing of children. Lillian Wald, a nurse and founder of both the Visiting Nurse profession and the Henry Street settlement in New York City, was the first person to suggest a federal Children's Bureau: “Experience in Henry Street, and a conviction that intelligent interest in the welfare of children was becoming universal, gradually focused my mind on the necessity for a Federal Children's Bureau.”¹ Wald famously went on to ask, “If the Government can have a department to look out after the Nation's farm crops, why can't it have a bureau to look after the Nation's child crop?”^{2,3} The creation of the Children's Bureau constituted the first public recognition that the federal government has a vested interest in and responsibility to promote the welfare of the nation's children.⁴ From the Children's Bureau “would flow knowledge of the conditions

surrounding children's lives, ideas on how to improve these conditions, and plans and programs for action."⁵

Early Mission and Research Efforts

The original mission of the Children's Bureau was to "investigate and report... upon all matters pertaining to the welfare of children and child life among all classes of our people," with special concern for "infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, [and] legislation affecting children in the several States and Territories." Congress's intent was that the studies and reports of the Children's Bureau would inform state and local efforts to improve the care of mothers and children.⁶ As stated by Senator Borah, reporting for the Senate Committee considering the 1912 Act: "The design and purpose [of the Bureau is] to furnish information . . . to the respective States to enable them to deal more intelligently and more systematically and uniformly with . . . the betterment of the condition of children and the more careful guarding of their welfare."⁷

The Children's Bureau existed as a single entity responsible for the health and wellbeing of the whole child from its establishment in 1912 until a 1969 reorganization split the Bureau, separating Maternal and Child Health activities (now in HRSA) from Child Welfare services (now in the Administration for Children and Families, or ACF). During the roughly 60 years that the Children's Bureau existed as a unified entity, it worked tirelessly on a variety of topics aimed at promoting the health and social wellbeing of the entire child. Key efforts of the Children's Bureau from its inception through the 1960s centered on:^{8,9,10}

- Health and Education Issues, with a focus on infant and maternal mortality, child nutrition, parent education, provisions for the care of crippled children, and maternal and child health.
- Social and Economic Issues, with a focus on pressing social issues of the day, including: protecting the legal rights of children born out of wedlock (1913-1916); developing the first Standards for Child Welfare (1919); generating legislation designed to provide pensions to mothers (1914-1920); contributing to the formulation of the Social Security Act (1934-1935); and leading national work on day care, child refugees, and child abuse legislation (1958-1962).
- Labor and Justice Issues, with a focus on child labor legislation (1916-1940); and juvenile delinquency, including issuing the first edition of Juvenile Court Standards (1923).

Through these initiatives and others, the Children's Bureau had a critical role to play in improving the health and wellbeing of children in the 20th century.

Reducing Infant Mortality

Under its originating Act of 1912, the Bureau was especially directed by law to investigate infant mortality. Efforts to comply with the law, however, were hampered by imperfect collection of birth statistics across the country. In 1913, the U.S. as a nation did not know for certain how many infants were born each year, how many died, or why they died. The first work of the Children's Bureau was to remedy this.¹¹

Birth Registration. In order to study infant mortality, it is necessary to know how many infants are born in a given year, and how many die before their first birthday. As a way to build

accurate information, Julia Lathrop, first Chief of the Children's Bureau, spearheaded birth registration drives across the United States. She wrote:

“We have no national bookkeeping to account for the ebb and flow of human life as an asset and a liability of our civic organism. We have no national records to give our sanitarians and students a basis for their preventive studies.... It is fair to say that there is a steadily increasing sense of the value of vital statistics, and that the number of States with good laws increases yearly.”¹²

With cooperation from the American Medical Association, the American Public Health Association, the American Bar Association, and the Bureau of the Census, the Children's Bureau was eventually successful in its drive for birth registration across the country.

Johnstown Study. In 1913, birth registration was reported to be complete in Johnstown, PA, and the newly-created Bureau started “at once”¹³ on a study of infant mortality there. The study found that poor parents lacked medical care during childbirth, depending instead on midwives, neighbors, or self-care. In addition, Johnstown and similar studies conducted by the Children's Bureau in eight other cities concluded that poverty was the single most important factor in infant mortality;¹⁴ as Katherine Oettinger, fifth Chief of the Children's Bureau, noted: “low earnings and high infant death rates went hand in hand.”¹⁵ Specifically, high infant mortality rates were associated with unsanitary conditions such as poor housing, open sewers, and unsterilized milk and nursing bottles.¹⁶ These early studies of infant mortality in nine cities also established a connection between the health of the mother and the child's own capacity to survive and flourish. These findings had an enormous impact on policies and practices:¹⁷

“These studies, the first of their kind ever undertaken by any nation, showed that the greatest proportion of infant deaths resulted from remedial conditions existing before birth. Death rates of babies went down as fathers’ earnings went up. Breastfed babies had a better chance to survive the dangerous first year than bottle-fed babies. A baby with his mother in the home during the first year of life had a better chance than a baby deprived of his mother’s care....These early studies had repercussions far beyond the Bureau. They gave great impetus to the drive for improved sanitary conditions...and for extending the pasteurizing of milk. They were used as an argument for minimum wage legislation and for widow’s pensions. They resulted in improvement of measures for safeguarding infant and maternal health in many States and communities.”¹⁸

These early studies thus resulted in changes not only in sanitation practices within the home, but also in changes in national policies affecting public health and welfare.



Child Care Publications for Mothers. The Children’s Bureau turned the knowledge they gained from these early infant mortality studies into practical advice aimed at saving the lives of mothers and children. “Prenatal Care,” first published in 1913, and “Infant Care,” first published in 1914, quickly became all-time best-selling Government publications. Published through the

1980sⁱ, these booklets for parents emphasized the importance of good nutrition, sanitation, and adequate medical care during pregnancy. As one mother wrote to the first Chief of the Children's Bureau:

“I should like very much all the publications on the care of myself, who am now pregnant, also on the care of a baby. I live sixty-five miles from a Dr.... I am 37 years old and I am so worried and filled with perfect horror at the prospects ahead. So many of my neighbors die at giving birth to their children. I have a baby 11 months old now in my keeping, whose mother died. When I reached their cabin last Nov. it was 22 below zero, and I had to ride 7 miles on horse back. She was nearly dead when I got there, and died after giving birth to a 14 lb. boy.... Will you please send me all the information for the care of myself before and after and at the time of delivery. I am far from a doctor, and we have no means...”¹⁹

In addition to the promotion of birth registrations and parental education, the second Chief of the Children's Bureau, Grace Abbott, continued to work on reducing infant mortality through Bureau efforts to facilitate cooperation between state health officials and health professionals, and to establish infant welfare and maternity centers.

In 1922, the Surgeon General of the United States, H.S. Cumming, reported that a conservative estimate of the U.S. infant mortality rate in 1910 was 124 deaths per 1000 live births.²⁰ By 1920, the infant mortality rate in those areas for which birth registration was completed was 86. By 1950, the U.S. infant mortality rate was 29.2,²¹ and in 2009 it was 6.4.²² The efforts of the Children's Bureau towards registering births, studying and addressing causes of infant mortality, training care providers to change their clinical practices, and educating

ⁱ The last Prenatal Care edition was 1983; the last Infant Care edition was 1989.

parents regarding healthy prenatal and infant practices all contributed significantly towards the reduction in infant mortality that occurred in the nearly 100 years between 1910 and 2009.

Child Health and Nutrition

Among its original mandates, the Children's Bureau was directed to investigate "diseases of children." One of the first diseases selected for study was rickets. As Grace Abbott, Children's Bureau Chief 1920-1934, wrote in her annual report to Congress in 1924: "The importance of preventing rickets arises from the great prevalence of the disease, the resulting danger to the lives of infants . . . and the consequent economic loss to the community."²³ Specifically, by impairing nutrition and the child's resistance to infection, rickets left the child vulnerable to diseases such as severe pneumonia, measles, whooping cough, respiratory illnesses, and death related to these diseases. In 1924-1927, Martha Eliot, then Director of the Children's Bureau's Division of Child and Maternal Health, studied rickets in New Haven, Connecticut, and demonstrated how mothers could be taught simple measures which greatly reduced the incidence of rickets.²⁴ According to Charles P. Gershenson, director of research in the Children's Bureau from 1963-1972, the fact that U.S. children are rarely seen with rickets today is due, in no small part, to Children's Bureau studies in the 1920s of vitamin D nutrition.²⁵

Maternal Mortality

Julia Lathrop, founding Chief of the Children's Bureau, wrote in 1916: "The sickness or death of the mother inevitably lessens the chances of the baby for life and health. . . . The Children's Bureau studies of infant mortality in town and country reveal clearly the connection between maternal and infant welfare and make plain that infancy can not be protected without the protection of maternity."²⁶ The Children's Bureau studies of maternal death during childbirth

had a profound impact on the health of women and children. One such study, conducted in 1927-28, involved investigating the deaths of about 7500 women:

“Just what did such a study involve? A look at some of the field reports showed that it meant riding muleback over remote trails in the Kentucky mountains, driving over the endless Western prairies, visiting big hospitals in crowded cities, and the cabins of granny midwives in the far South. It meant going anywhere and everywhere that the records showed a mother had died and filling in a detailed schedule with information which might throw light on the cause of her death.”²⁷

The results of this study indicated that a large proportion of women had little or no prenatal care, and little or very poor care during birth. Forty percent of deaths were due to sepsis. The recommendations drafted by the Children Bureau’s advisory committee on obstetrics on the basis of this study led to the adoption of standards for maternal care, and to increased efforts to educate the public regarding the need for adequate medical care during childbirth. In 1915, the maternal mortality rate in the U.S. was estimated at 607.9 deaths per 100,000 live births for the birth registration area; by 2003, this number had dropped to 12.1 deaths per 100,000 live births.²⁸ Once again, the research undertaken by the Children’s Bureau had a marked impact on the health and wellbeing of women and children in the United States.²⁹

The Protection of Mothers and Infants

In 1917, Children’s Bureau Chief Julia Lathrop prepared a report for Congress which contained a plan for the “Public Protection of Maternity and Infancy with Federal Aid.” This plan was a direct outgrowth of the Bureau’s early infant mortality studies. As Lathrop observed, “The understanding is growing in the United States that permanent success in reducing infant

mortality can be achieved only in connection with the protection of mothers.”³⁰ The Children’s Bureau’s plan translated the findings of its early infant mortality studies into programs of health and social welfare services for families across the nation, as well as into legal action in the states and communities. Her report emphasized the importance of a nationwide program that included: public health nurses for instruction and service to mothers; instruction in schools and universities covering the field of hygiene for mothers and children; centers for the examination of well children; adequate confinement care; and hospital facilities available and accessible to mothers and young children in rural areas as well as cities.³¹ In response to this report, the concerns raised in it, and much active campaigning on the part of the Children’s Bureau, the Sheppard-Towner Act was passed.³²

Sheppard-Towner Act

The 1921-1929 Maternity and Infancy (Sheppard-Towner) Act (PL 67-97) resulted in federal grants-in-aid to states for child and adult health programs; it also resulted in the development of full-time units of maternal and child health services in state health departments, and provided training for nurses. This was the first U.S. federal grants-in-aid program to the States for health. It was highly controversial and labeled “radical” and “socialistic” by its critics. Ultimately, it was repealed, but not before disagreement about it within the American Medical Association resulted in the formation of the American Academy of Pediatrics in 1930.³³ Today, the Sheppard-Towner Act’s brief existence reminds us not only of the importance of public investment in children’s health, but also of the critical role that research findings can play in setting new policies which become implemented into services and programs that exemplify the translation of new knowledge into improved health and wellbeing for children.

Focus on the Child as a Whole

In addition to its research on infant and maternal mortality, and child health and nutrition, from its founding in 1912 through the 1930s the Bureau investigated a comprehensive range of issues affecting the health and wellbeing of the child as a whole, such as: services for children with disabilities; child labor; foster care; children of working mothers; juvenile delinquency; and the effects of unemployment on children during the Great Depression. These research activities found fruition in legislation and social programs such as the:

- Development of the first Standards for child welfare (1919);
- Establishment of Mothers' Pension Plans in 40 states (1914-1920);
- Enactment of the Fair Labor Standard Act of 1938, which established a minimum age of 16 for general employment, and also set a floor on wages and a ceiling on hours.

These programs and others like them served to improve the health and wellbeing of children throughout the United States. They were all built on the Children's Bureau's early dedication to the mutually reinforcing premises that, in order to better the condition of all children, we must:

- Conduct research that will help us understand and define the extent of a given problem, as well as the "social and economic conditions under which it flourishes,"³⁴ and the factors which may serve to ameliorate it; and
- Translate those research findings into legislative action which, when implemented, benefits families at the state and community level.³⁵

The Passage of the Social Security Act

In 1934, President Roosevelt's Committee on Economic Security, tasked with preparing legislation for the Social Security Act, sought the advice of the Children's Bureauⁱⁱ regarding the inclusion of programs for children.³⁶ The Bureau proposed programs in four major areas:

- Program of aid to dependent children;
- Child welfare services;
- Maternal and child health services; and
- Medical care for crippled children

The Bureau's proposal was based on expertise it had built through its research efforts, as well as through its experience administering the Sheppard-Towner Act. The Children's Bureau's findings and recommendations were approved by the President's Economic Security Committee, and were eventually incorporated into the Social Security Act itself.³⁷ As enacted, the Social Security Act of 1935 included:

- Aid to Dependent Children, Title IV Part A;
- Child Welfare, Title IV Part B;
- Maternal and Child Health (MCH) and Crippled Children's Services (CCS), Title V.

The Social Security Act was signed into law on August 14, 1935. In it, Congress gave the administration of the Title IV and V programs to the Children's Bureau. According to Arthur Lesser,ⁱⁱⁱ the successful passage of the Social Security Act in 1935 represented the confluence of

ⁱⁱ Specifically advising the Committee were Grace Abbott, second Chief of the Children's Bureau; Grace Abbott's sister, Edith Abbott; Katharine Lenroot, appointed third Chief of the Bureau in 1934; and Dr. Martha May Eliot, adviser on the medical aspects of child health who went on to serve as the fourth Bureau Chief from 1951-1956.

ⁱⁱⁱ Arthur J. Lesser, MD, MPH, joined the Children's Bureau in 1941 and became Director of the Division of Health Services in 1952. At the time of the 1969 reorganization he was Deputy Chief of the Children's Bureau, where he

a variety of forces, including:³⁸ (1) a growing recognition that the federal government bears a responsibility for promoting and protecting the health and wellbeing of children; (2) evidence which emerged during the Depression that resources for the care of special needs children were virtually nonexistent, and that 23 states lacked any funds for maternal and child health, even while the maternal mortality rate in the US was much higher than in other progressive countries; (3) an increasing belief that recovery from the Depression necessitated taking measures that would prevent the destitution of children and their parents; and the growing conviction that special measures protecting children must be an essential part of the nation's economic security program—that “the core of any social plan must be the child.”³⁹ As articulated by Martha Eliot, Children's Bureau Chief 1951-1956: “In a very real sense the child is the touchstone. What we do for him we do for all mankind; what we do for adults, we also do for children. . . . Our children are indeed our measure of social progress.”⁴⁰

The Social Security Act served as a launching pad for a national program designed to protect maternal and child health and wellbeing. It was the ongoing research efforts of the Children's Bureau, as well as its activities under the Sheppard-Towner Act, that laid the foundation for this major legislation designed to protect and promote the health and welfare of the country's most valuable resource: its children.

had oversight of the divisions responsible for MCH and CCS programs and research; he led these programs from the Children's Bureau to the Public Health Services, where they have resided ever since.

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Research Program
Part 2: 1935-1969**

“Because of you: we had another chance, and babies by the millions can advance.”

*--From a poem sent by Bettye Caldwell to Charles P. Gershenson,
Children's Bureau, upon receipt of a research grant to establish the
Children's Center in Syracuse, New York, 1964*

An Extramural Research Program for the Children's Bureau

Over time, the Children's Bureau had articulated a fundamental mission with two interrelated aims. As described by Helen Witmer, Director of Research in the Children's Bureau from 1951-1967:

“First, [the Bureau] aims to assemble the facts needed to . . . keep the country informed about matters that adversely affect the welfare of children. Secondly, it aims to determine what kind of health and welfare measures and methods are most effective in aiding children and their needs. . . . The carrying on of programs requires information about needs. Vice versa, having secured the facts about the handicaps under which numerous children live, we naturally want to know by what means they can be diminished.”⁴¹

Although both knowledge and the action and service programs that flowed from it had served as the Children's Bureau's driving mission since 1912, the articulation of these goals into an integrated, external research program didn't begin until midcentury. In 1953, Helen Witmer wrote that the Bureau's dual aims “provide the basis for an integrated research program . . . chiefly concerned with answering practical questions about the wellbeing of children.”⁴² In a presidential address to the American Public Health Association in 1948, Martha May Eliot, then Associate Chief of the Children's Bureau, stated that “without an underlying structure of

research and investigation . . . from which new facts will flow, the service programs will sooner or later deteriorate and fail.”⁴³

Eliot and Witmer’s leadership in establishing an external research program at the Children’s Bureau found impetus in the support it received from professionals and advocacy organizations across the country. During the postwar 1940s and 1950s, the Social Work Research Society was formed, which met periodically to discuss research concepts and practice. Included in the group were professors teaching research at Schools of Social Work, as well as David Fanshel, who became the Research Director of the Child Welfare League of America in 1957. Members of the Society also met with Helen Witmer at conferences, and began suggesting federal support in specific areas of child welfare research. At the same time, Joseph Reid, Executive Director of the Child Welfare League and a leading friend of the Children’s Bureau, was urging Congress to give the Bureau research and demonstration funds for child welfare. ⁴⁴

In the meantime, on the Health side, Children’s Bureau Chief (1951-1956) Martha Eliot worked closely with Chairs of Maternal and Child Health (MCH) Departments in Schools of Public Health, who had organized to promote MCH teaching and research. According to Charles Gershenson, “Helen [Witmer] was brilliant in pulling together these streams of support and convened a group to review the Children’s Bureau’s past research efforts in order to guide a program for the future. For MCH, Martha [Eliot] was the visionary and leader in service and research.”⁴⁵

Emergence of the Extramural Program after a Time of Research Slow-Down

What precipitated this desire to develop the Bureau’s research infrastructure at this particular point in time? There appear to have been several factors at work.

Passage of the Social Security Act. First, the passage of Titles IV and V of the Social Security Act of 1935 underlined the success of the Children’s Bureau in bringing children’s needs to national attention. However, these were and remain large and complex sets of programs. Focused on extending and improving services that promote the health and wellbeing of mothers and children, their scope expanded from 1936-1939 to include not only the three originally targeted parts of the legislation (MCH, CCS, and social welfare), but also appropriations for special projects first for MCH and then for CCS.^{iv} The administration of the new programs consumed considerable time and attention: “After the passage of the Social Security Act much of the Bureau’s research time was given to devising the statistical reporting system needed to underpin program research as an aid to good administration of the grants.”⁴⁶ Although “much-needed facts” were obtained through this statistical reporting system, the balance within the Bureau tilted slightly towards programmatic as opposed to research efforts.

Suspension of Research Efforts during World War II. Second, although the Children’s Bureau continued to conduct research during the 1930s and early 1940s^v, America’s entry into World War II meant that research programs which could not be justified as contributing to the war effort had to be dropped according to a general policy that affected all federal agencies.

^{iv} Funding for the Title V expansion was accomplished through the appropriations language. Specifically, it was stipulated that half of the Title V formula grant money allotted to States—Fund A—would be matched dollar for dollar by the States; the other half—Fund B—would not require matching, but would be distributed on a per capita basis, such that poorer states received proportionately more money from Fund B. At the same time, money was reserved from Fund B to provide for ‘special projects of regional and national significance’ (SPRANS). These special projects advanced important programmatic goals, such as demonstrating how new knowledge could be translated into practice, developing programs for children with diagnoses not originally included in the legislative language, and supporting graduate professional training. Examples of the types of special projects undertaken include services for: the care of preterm infants; women with pregnancy complications; children with hearing impairment, mental retardation, congenital heart disease, and other health conditions; and grants to institutions of higher learning for the training of nurse-midwives, social workers, physicians, and other related specialties including public health.

^v E.g., the physiology and care of preterm infants; the work and welfare of children growing up on farms; the effect on children of conditions in defense production areas.

During the War years, research activities at the Bureau all but ceased^{vi}. This “undid the balance” that existed in the Children’s Bureau between research and fact-finding on the one hand, and on the other, programs of advisory services and administration of grants-in-aid to the States.⁴⁷

Structural Reorganization. Third, in 1946 a major reorganization removed child labor activities from the Children’s Bureau, and also moved the Bureau itself from the place it had long held within the Department of Labor, where it had reported directly to the Secretary. The change was significant. Whereas previously the Bureau had enjoyed relative independence and prominence within the federal government and the nation at large, it was now housed in the Social Security Administration within the Federal Security Agency^{vii}, two levels down in the hierarchy in a non-Cabinet agency.⁴⁸ Concerns were expressed by many that “just as the Bureau was created ‘to make children visible throughout the Nation,’ so the Children’s Bureau itself must be visible . . . if it is to contribute its best to the wellbeing of children.”^{49,50} Notably, structural reorganizations often spark rethinking of an agency’s mission and how best to achieve it; the Children’s Bureau in 1946 was no exception.

Growth of Knowledge. Finally, the state of knowledge about children’s health and welfare had itself changed since 1912. Nowhere was this clearer than with the Midcentury White House Conference on Children and Youth. The White House Conference, organized by the Children’s Bureau and held every decade from 1909-1971, saw its largest attendance ever in 1950; over 450 national organizations and almost 6000 national and international delegates participated in this Conference, which was focused on children’s mental health and personality development.⁵¹ In preparation for the event, Helen Witmer led a “fact-finding” initiative, which

^{vi} Although research efforts ceased, Martha Eliot was instrumental in implementing the Emergency Maternity and Infant Care (EMIC) program, which provided health care to more than one million military families during World War II.

^{vii} In 1953, the Federal Security Agency became the Department of Health, Education, and Welfare (HEW).

was responsible for synthesizing needs-analyses from all States with other available information related to children's mental health and personality development. The task was substantial, the topic was largely unexplored, and researchers were beginning to demonstrate a notable awareness of the socioecological context of child development, leading Conference Executive Director Melvin Glasser to rhapsodize that:

“There are relatively few branches of study that may not have something to contribute to [the topic of children's mental health and personality development]. The family is basic and strategic.... The factors that contribute to a child's personality undoubtedly lie in his physical condition, the personal atmosphere of his home, his relation to the community, the type of community he finds himself in. All these aspects of the problem must be understood before we can plan for healthy personality development. When all the facts are in, the most important thing brought to light will probably be the gaps--the unanswered questions—that will show us where further study should be made.... To direct such research or organize such practice is beyond the power of any one committee or organization.”⁵²

One of the most striking results to emerge from the Midcentury Conference on Children and Youth was a paper written by Kenneth B. Clark entitled, “The Effect of Prejudice and Discrimination on Personality Development.” The Supreme Court used this paper, and cited the findings of the Conference's Report, in its *Brown v. Board of Education* decision that outlawed racial segregation in the public schools in 1954.⁵³

Proposal for a New Research Program

Helen Witmer, who had led the fact-finding mission for the Midcentury Conference, clearly agreed with Glasser's assessment that such an undertaking was ‘beyond the power of any

one committee or organization.’ Following her appointment as the Children’s Bureau’s Director of Research in 1951 by Martha Eliot, she began developing position papers outlining the need for an applied research program at the Children’s Bureau. In 1953, she wrote:

“The area indicated by [questions related to maternal and child health and welfare] is largely an untilled field so far as scientific research is concerned. . . . There has been little scientific research in regard to either social services or the social aspects of public health. In both . . . fields, however, there is growing interest in applying scientific method to the collection and analysis of social data for the purposes of determining the effectiveness of programs and of testing the hypotheses on which programs for children are or might be based. . . . In view of our present knowledge of how important the environment and experiences of childhood are for the full development of human beings’ potentialities . . . it is surprising that this is so. The Children’s Bureau, of course, cannot take on this whole job. Given funds and a creative staff, it can, however, provide leadership in this area and can play an important part in mobilizing scientific effort in this regard.”⁵⁴

In her writings, Witmer calls 1951 the turning point in a new vision of research for the Bureau—a time when “the Bureau could take staff time to review closely how it had carried out its investigatory responsibility under the 1912 Act and to consider how its research under [this Act] was related to operations under the Social Security Act.”⁵⁵ From this time of reflection, it was “proposed that the Bureau take as the prime focus of its investigations children whose health and welfare are in jeopardy . . . The aim of the research would be to add to the store of knowledge needed for sound formulation of social policy and for the effective carrying out of services in children’s behalf.”⁵⁶ In today’s terms, the Bureau’s new “integrated program of research” was to focus on applied research targeting underserved or vulnerable populations.

In November of 1956, Witmer supplied language for new legislation:

“The fundamental fact about the Children’s Bureau’s proposed cooperative research bill is that it authorizes the Bureau to make grants and enter into contracts, etc. in order that the Bureau may carry out more effectively, more efficiently, and at lower cost, one of its long-standing responsibilities. The Bureau already has the authority to conduct studies and investigations [through the Act of 1912]. . . . The proposed legislation, then, is designed to enable the Bureau to carry out more adequately the kind of work it has been engaged in for nearly half a century. . . . Even if the Bureau’s research staff were to be greatly expanded, it still would be more economical and efficient to utilize outside research organizations and practitioners for carrying on much of the work.”⁵⁷

The research bill proposed by the Bureau in the 1950s included not only language for external research grants, but also for funds that would support training in research “in order to increase the supply of research workers who are competent to do the applied and developmental studies and the fact-finding investigations that the Bureau’s program calls for”.⁵⁸

The bid, supported by physicians, professional organizations, and citizens’ groups,⁵⁹ was successful. In 1960, Congress approved an amendment to Title V authorizing extramural research and demonstration projects in child welfare.⁶⁰ In 1961, President John F. Kennedy, who had deep personal interests in mental retardation, appointed a Panel on Mental Retardation to consider “better use of existing knowledge.” As Lesser described, “Basic to reducing the incidence of mental retardation is the improvement in the quality of maternity care for the large group of women in low-income urban and rural areas. . . . The lower the birth weight, the higher the incidence of neurological disabilities and mental retardation.”⁶¹ The Panel in its report concluded that “efforts to cope with the problem of mental retardation must emphasize the

possibilities of prevention,”⁶² and in his message to Congress in February, 1963, President Kennedy affirmed, “the relationship between improving maternal and child health and preventing mental retardation is clear”.⁶³

On October 24, 1963, President Kennedy signed the Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act (PL 88-156). Among other provisions, the amendment authorized appropriations for “grants, contracts, or jointly financed cooperative agreements for research projects to improve maternal and child health and crippled children’s services.” The Children’s Bureau now had external research programs in both child welfare and child health, and for the first time “had money to use extramurally, to go outside what had been since 1912 the internal ‘investigate and report’ function and role of the Children’s Bureau. So it was an exciting opportunity for everyone concerned.”^{64viii}

Extramural Research in the Children’s Bureau, 1960s

Charles P. Gershenson, child psychologist and Research Director of a child welfare agency in Chicago, came to Washington, DC, in 1963 to help set up the child welfare research program, and then a year later the maternal and child health research program; at first a contract employee, he joined the Children’s Bureau as Assistant Director of Research in 1965, working under Helen Witmer. Katherine Oettinger was by then fifth Chief of the Children’s Bureau (1956-1967), and Arthur Lesser, a public health physician who later led the MCH Research Program into what is now HRSA, was Deputy Chief.

“One day I got a call from Helen Witmer whom I had met at conferences. I really did not know her personally but had read her publications. I knew she was head of

^{viii} Training programs were also authorized for child welfare (1962), and “professional personnel for health and related care of crippled children” in 1965.

research at the Children's Bureau. Would I come to Washington to set up this new child welfare research program? . . . What I found when I came to Washington was an ethos, a feeling, of real commitment to children and mothers. . . . Anything we did had to have some very practical application and that is the history of the Children's Bureau. . . . The zeitgeist was real life problems."⁶⁵

In the vibrant years that followed, as new federal funds became available not only through the Children's Bureau but also through the newly-established National Institute of Child Health and Human Development (NICHD), research in children's health and wellbeing underwent a renaissance. Two Children's Bureau efforts in particular stand out among the many: research creating the first Infant-Toddler Centers, and research on adolescent pregnancy.

Infant-Toddler Centers

The Infant-Toddler Centers began with a call to Katherine Oettinger, then Chief of the Children's Bureau, from Marion Rosenwald Ascoli, a philanthropist and president of the Citizens Committee for Children of New York. According to Charles Gershenson,⁶⁶ at that meeting, Mrs. Ascoli, along with psychiatrist and author David M. Levy, described a problem that New York hospitals were experiencing: there were many abandoned newborn infants in the hospitals, most of them African American, who were remaining in the hospital for as long as 11 months due to limited adoption options in existence at that time; the hospitals didn't know what to do with these children. Could the Children's Bureau do something to address this problem?

"By just sheer coincidence, almost like a week later, I get a call from the Dean of the Medical School at Syracuse University, Julius Richmond. He and I knew each other from Chicago. . . . He asked whether we would be interested in supporting a program dealing with inner-city poor children, primarily African American children, and seeing what can

be done to enhance their development, particularly school preparation and cognitive development. He had a young investigator who just came from St. Louis. He'd hired her husband, a physician, at the medical school, and she was a psychologist, by name of Bettye Caldwell. My mind connected with that visit from New York, and I said, 'Would you be interested in developing an infant-toddler care, child care demonstration?' He said, 'Oh, that's directly in line with what we were thinking of.' I asked him to send me a grant proposal."⁶⁷

Richmond and Caldwell's work at Syracuse attracted the notice of Sargent Shriver, then Director of the newly-formed Office of Economic Opportunity (OEO), and architect of President Johnson's War on Poverty program. In 1964, backed by presidential interest, Shriver created a small planning committee that included Julius Richmond, psychologist Edward Zigler, sociologist Edmund Green, and pediatrician Robert J. Haggerty. Out of this planning committee, a summer program was born, which they decided to call "Head Start" following a particularly exuberant midnight meeting.^{68ix} Head Start's origins are complex and multifaceted⁶⁹, but Richmond and Caldwell, whose demonstration project served as one model for the popular program, were there at the beginning with work funded through a grant from the Children's Bureau^x.⁷⁰

Adolescent Pregnancy

A second major social issue tackled through the newly-created external research program at the Children's Bureau was that of adolescent pregnancy. According to Gershenson:

^{ix}Following Head Start's original conception as a summer program, a 13-member planning panel was commissioned by President Johnson in 1964 to introduce Head Start as a national, year-long program. Jule Sugarman served as Executive Director of this panel, and went on to become Head Start's founding Director.

^x During the time that Head Start was originally conceived, Richmond and Gershenson shared an apartment in DC. Gershenson was still commuting between Chicago and DC before moving his family permanently to Maryland, and Richmond was on special detail to the OEO from Syracuse; much information was shared informally between the two men.

“One of our big drives was reducing infant mortality. [One day Arthur Lesser and I began chatting about] a study coming out of New York . . . showing the high infant mortality among unwed mothers . . . and how can we reduce it? . . . A month later, the principal of the Sharpe Health School in D.C. [Elizabeth Goodman] came to see me. . . . The Sharpe Health School was the public school for handicapped children in those days, and she had pregnant girls. ‘But we don’t keep them in school,’ she said. ‘They stay at home and we send a teacher to teach them.’ I asked, ‘Well, how many girls does a teacher handle?’ She says, 8 to 10, and she’d like some money from us to pay for two more teachers. I asked, ‘Well, how many girls do you estimate in D.C. would need to be served?’ ‘There are about 200 but I don’t want money for all 200,’ she replied. I said, ‘It doesn’t make sense. Would you consider keeping them in school and I’ll support a program of comprehensive services?’ . . . She submitted an application and we funded it.”⁷¹

The Webster School Project^{xi} began in the fall of 1965 to media fanfare calling public attention to the “new school for unwed mothers.”⁷² The program offered comprehensive services that provided over 200 pregnant teens with prenatal health care, and assisted them with decisions regarding adoption, motherhood, and their future lives while they continued in school. With the education of pregnant adolescents garnering national attention, Gershenson conducted a telephone survey of school systems around the country regarding how they handled pregnant students. He found that invariably they were expelled.⁷³ Oettinger later recalled that, “[Dr. Gershenson and I were both] delighted with the early reports of progress and it was not long before other schools, who read the subsequent reports over a three-year period, began to initiate

^{xi} The program for pregnant girls that Elizabeth Goodman started held classes at the Webster School, where the Board of Education’s administrative offices were located.

similar opportunities for girls throughout the country.”⁷⁴ By 1967, at least 35 communities across the U.S. were providing coordinated educational, health, and social services to pregnant students, with more being planned.⁷⁵ By 1972, this had increased to over 150.⁷⁶ In addition, the 1967 amendments to Title V earmarked 6 percent of the MCH appropriation for family planning services.⁷⁷

It then occurred to Gershenson that the infant-toddler centers could be combined with the adolescent pregnancy effort:

“If you’re going to keep the pregnant girls in school, what do you do with the infants? Here I had this other program [first funded with Bettye Caldwell] developing infant care. So some of the schools [serving teen mothers] set up infant care programs, and the postpartum mother could continue school and the infant would be cared for and they would learn about child development.”⁷⁸

Once again, the Children’s Bureau had used its research efforts to address pressing social issues; the outcomes of these research and demonstration projects had social import for the health and wellbeing of children and youth across America. As Gershenson notes nearly 50 years later, “This was exciting for me, carrying out the tradition of the Children’s Bureau. I consider my 25 years there as a continuous learning experience in achieving social change.”⁷⁹

Reorganization

As mentioned above, the 1946 reorganization had moved the Children’s Bureau from a prominent position directly below the Secretary of Labor, to a third-level position within a non-Cabinet agency. More than once in the late 1950s, Congressman John Fogarty, chair of the subcommittee that provided funds for the Departments of Labor, Health, Education and Welfare, questioned HEW Secretary Arthur Flemming regarding the proposed budget for the Children’s

Bureau. A strong advocate of children's health, Fogarty noted that the full amount appropriated by Congress for the Bureau was not reflected in the proposed budget, and asked at a February 1960 budget hearing: "Do you think this is enough, what you're requesting for the Children's Bureau? . . . There's increased interest all over the country in these programs."⁸⁰

In conversations with Children's Bureau Chief Katherine Oettinger, Fogarty urged her to advocate for the full amount appropriated for the Children's Bureau. She did not, choosing instead to express her loyalty to Secretary Flemming and the budget request he put forward. Later, at a hearing on March 14, 1961, Chairman Fogarty told incoming HEW Secretary Abraham Ribicoff, "We have often thought that more could be done with the Children's Bureau. You have the authority to expand their program considerably.... Am I right in saying you have the authority to raise it to a higher organizational level?" The answer was yes, "it does not require legislation to change the organizational location of the Children's Bureau within the department. We can take it out from under the Social Security Administration, if that is what you mean." Fogarty answered, "Yes, the way it is it doesn't get the recognition it deserves."⁸¹

Fogarty's desire to raise the status of the Children's Bureau was not realized. At a hearing before Congress on April 13, 1961, a task force report was mentioned that had been written by Wilbur Cohen, newly appointed Assistant Secretary for Legislation of Health, Education, and Welfare. In the report, Cohen recommended that the Bureau's functions be dismembered, placing the health functions in the Public Health Service, and making the Children's Bureau a consultative agency.⁸² At the April 1961 hearing, Congressman Melvin Laird asked Oettinger, "Could you handle a research program in the area of child health through the Children's Bureau?" In response, Oettinger stated, "In the early days of the Children's Bureau, as you know, we did a great deal of basic research, but over the years it is true that the National

Institutes have been encouraged, and have had additional funds that makes it expected that they will do the basic and fundamental research. We could handle the related programs we call ‘program research’, related to those things which have to do with our program operations.”⁸³ Thus, despite very favorable backing in Congress, Oettinger accepted the proposition that the Children’s Bureau’s mission did not include basic research.^{xii}

On Cohen’s recommendation, the Kennedy administration allotted the function of basic research in child development to NICHD, newly established in 1962. The Children’s Bureau maintained control over the external research funds for child welfare and health allotted to it by the 1960 and 1963 amendments. This resolution, consistent with the vision that had been promulgated by Eliot and Witmer in the 1950s, seemed a peaceful one in the early 1960s, and the Children’s Bureau’s extramural research programs flourished; however, the stage had been set for a reorganization in 1969 that would fundamentally alter the nature of the Bureau.

During the 1960s, the Children’s Bureau underwent three moves within the federal government. In 1963, based on Wilbur Cohen’s recommendation in his 1961 Task Force report, the Children’s Bureau was moved from the Social Security Administration to the newly-created Welfare Administration, where presumably it could operate more effectively in coordination with other government welfare functions.⁸⁴ In 1967, the Welfare Administration was phased out and Cohen moved the Children’s Bureau into the Social and Rehabilitation Service (SRS), believing that “we could use a rehabilitation framework to move people out of welfare”.⁸⁵

According to Gershenson, Oettinger resigned as Chief “on the spot and would not move” to

^{xii} It is unclear to what extent Oettinger was acting out of loyalty to her Secretary, and to what extent she herself believed that basic versus problem-focused research was the best way to distinguish between the respective missions of the Children’s Bureau and NICHD. As noted by Charles P. Gershenson, “The definition between [basic versus problem-oriented research] was unclear, and the Children’s Bureau was engaged in . . . research of the social issues affecting children rather than lab work on children's illnesses” (personal communication to the 1st author, May 8, 2012).

SRS.⁸⁶ Oettinger was appointed Deputy Assistant Secretary of Family Planning—a position that in large part grew out of the adolescent pregnancy initiatives of the Children’s Bureau. In 1968, P. Frederick DelliQuadri was appointed Chief—the first man to hold this position. He resigned within a year after taking the position, at the beginning of the Nixon administration.⁸⁷

1969

In January of 1969, the Children’s Bureau within the SRS consisted of six Divisions^{xiii} (plus 10 regional offices across the States): Health Services (Title V program administration); Family and Child Welfare Services (Title IV program administration); Research; Work and Training; Early Childhood (day care, preschool, and community coordinated child care); and Reports and Information. The Health Services and Research Divisions, which administered all Title V funding including the extramural research programs, both reported directly to the Deputy Chief, Arthur Lesser.⁸⁸

At that time, Head Start was housed within the Office of Economic Opportunity (OEO), where it had begun under Sargent Shriver as part of Johnson’s War on Poverty. Head Start, however, had quickly become a highly visible and popular national program. As early as 1967, Congress had made attempts to move Head Start out of OEO into Education (then in HEW).⁸⁹ At the same time, Jule Sugarman, Head Start’s founding Director in OEO, had become Associate Chief of the Children’s Bureau in April, 1968; he argued strongly that a move to Education would “lead to a wholesale reduction of meaningful participation by parents, volunteers, and nonprofessional personnel,”⁹⁰ and advocated that Head Start be moved to the Children’s Bureau. However, HEW Secretary Robert Finch recommended that neither Education nor the Children’s Bureau would get Head Start; instead, a new Office of Child Development would be established

^{xiii} Juvenile delinquency services, for 50 years a consistent theme of research and action within the Children’s Bureau, had been moved to other agencies, including the Department of Justice, before the 1967 reorganization.

directly under Finch, and Head Start would be transferred there. This new Office would also take over the Children's Bureau's day care programs.⁹¹ In establishing the new OCD, Finch maintained that he was implementing President Nixon's charge for a "national commitment to providing all American children an opportunity for healthful and stimulating development during the first 5 years of life", by creating the opportunity for closer coordination among the Department's early childhood programs.⁹²

On September 17, 1969, HEW Secretary Finch announced a reorganization which: (a) moved the Children's Bureau out of SRS and into the new Office of Child Development (OCD), which was directly under Finch; (b) left child welfare in SRS; and (c) moved the health programs administered by the Children's Bureau into what was then the Health Services and Mental Health Administration (HSMHA, now HRSA).

Why was the Children's Bureau finally split apart, in the third reorganization after Cohen first proposed a division in 1961? One explanation is that the Bureau was a victim of its own success. As it spearheaded new research and activities that generated national attention, these children's causes were then taken up in other federal agencies: juvenile delinquency in the Department of Justice, basic research on child development in NICHD, and so on. In addition, the 1960s were, under the Kennedy and Johnson administrations, a time when new social policy with respect to children's needs commanded wide public support.⁹³ In 1960, the White House Conference on Children and Youth generated over 600 separate recommendations/ statements about children; over 40 of these were taken up by Congress, and later realized in amendments to Titles IV and V.⁹⁴ As programs and research targeted to children's concerns grew exponentially across agencies, many came to believe that their administration could happen most efficiently when topically similar services were consolidated. From the administration's perspective, why

shouldn't Head Start and the Bureau's early childhood programs exist together? Similarly, the PHS focused on health; why shouldn't maternal and child health combine with other health services? In 1967, Martha Eliot wrote that⁹⁵:

“The current proposal to transfer the health functions of the bureau to the Public Health Service is reminiscent of [previous debates]. . . . The problem of what to do with the Children's Bureau, which cuts across [child welfare, health, and education], is, as always, a hard one to resolve. . . . The basic questions are: Is it still essential to have in the federal government an agency that concentrates all its thought and effort and works continually to improve the conditions of life that make for healthy development of the child? . . . If either the maternal and child health or child welfare activities are removed, the voice of the advocate for children will become dim or lost.”

However, the concept of focusing on the “whole child” in a multidisciplinary fashion seemed antiquated and clumsy for an age that prided itself on increased specialization. In September, 1969, the Children's Bureau was divided into three parts^{xiv}: (1) child welfare services and child welfare training programs stayed in SRS; (2) research and demonstration projects in child welfare became the joint responsibility of OCD and SRS; and (3) maternal and child health and crippled children's special projects, training, and research programs were moved under the leadership of Arthur Lesser into the Public Health Services into the agency that eventually became HRSA. The fight to move maternal and child health to the PHS, proposed as early as 1961, began actively in 1967 and included, according to Gershenson, not only Congress, but professional organizations with ties to the MCH programs:⁹⁶

^{xiv} Under Title IV of the Social Security Act were child welfare services; under Title V were the child welfare training programs, research and demonstration projects in child welfare, and maternal and child health and crippled children's special projects, training, and research programs. Thus, Title V activities focusing on child welfare were separated from other aspects of Title V.

“Arthur Lesser had an Advisory Council that combined the Chiefs or the Department Heads of Maternal and Child Health, pediatric associations, and public health associations in an Advisory Council on Maternal and Child Health. . . . Lesser was superb in his relationship with these organizations, and winning their support, for example influencing Congress. Mary Switzer [head of SRS] abolished [the Advisory Council] the first week after [the Children’s Bureau was] absorbed [by SRS]. Well, I think it must have taken just about 48 hours later, I think it was not Arthur Lesser but these Council members who convened, called their contacts in Congress, and got authorization to move Maternal and Child Health out of the Children’s Bureau, away from Mary Switzer [whom they viewed as a threat to the MCH Program’s existence], into Public Health Service, and that’s how [MCHB] began as a PHS unit.”

Arthur Lesser, who had served as the Bureau’s Deputy Chief and had oversight of the Health Services and Research Divisions, was now Acting Director of a Maternal and Child Health Services in HSMHA; MCH was now sundered from the child welfare concerns with which it had been inextricably intertwined since 1912.

**Remembering our Past,
Building the Future:
100 Years of the Maternal and Child Health
Research Program
Part 3: 1969-2012**

“One thing is clear. We must increase still more our knowledge in this field of human relations—and having increased it, we must transmit it, we must use it.”

--Martha M. Eliot, 4th Chief of the Children's Bureau, 1948

Maternal and Child Health Research in the Public Health Service

Years of Transition

The transition to PHS for the MCH Research program was not an easy one. Lesser resigned in June, 1972, charging that the Nixon administration was not truly interested in the problems of children.⁹⁷ Gershenson lent continuity to what had been the Bureau's extramural research programs by splitting his time between OCD and MCHS; however, he left for an IPA with Brandeis and UNICEF in 1972. Following his return to the Children's Bureau in 1974, with Lesser gone and child health and welfare functions split geographically and organizationally, Gershenson lost contact with the maternal and child health research program.⁹⁸ The synergy between child health and welfare, which had defined the research and programmatic activities of the Children's Bureau since its inception, was gone.

In 1973, in yet another reorganization, the newly-named Office for Maternal and Child Health (OMCH) was moved into the Bureau of Community Health Services (BCHS) within what was now the Health Services Administration (HSA). At that time, OMCH itself was split into two parts, with administrative responsibility for Title V remaining in OMCH, and the rest of the staff (technical assistance, consultation, special projects, research, and training) moving to what was the Division of Clinical Services (DCS) within BCHS: “the [MCH] program had reached its low ebb, five levels below the cabinet and in two pieces. Federal oversight of state maternal and child health programs generally weakened during this era.”⁹⁹

Vince Hutchins began in MCH under Arthur Lesser as Regional Medical Director of Region III (Philadelphia), 1971-72.^{xv} In 1975, Ed Martin became Director of BCHS, and began gradually moving MCH staff out of DCS and back into the Office of MCH. Martin describes the MCH staff as bitterly unhappy over the internal split they had experienced¹⁰⁰. In 1977, Martin appointed Hutchins Associate Bureau Director of MCH. This marked the beginning of the MCH program's renewed autonomy and identity, under the leadership of Vince Hutchins. The MCH program was finally made whole again in 1982 when DCS was abolished and MCH became a Division within BCHS^{xvi}. In 1990, MCH became the Maternal and Child Health Bureau (MCHB), directly under the head of HRSA. Twenty-one years after the 1969 reorganization, the MCH program, stable at last, was finally its own Bureau.^{xvii}

The MCH Research Program within MCHB

In 1990, the newly-formed MCHB had what became three divisions: Maternal, Infant, Child, and Adolescent Health under David Heppel; Children with Special Health Care Needs under Merle McPherson; and Systems, Education, and Science (renamed Science, Education, and Analysis in 1995) under Woodie Kessel.¹⁰¹ Research and Training, headed by James Papai, was a Branch within Kessel's division. Under Papai, Gontran ("Tan") Lamberty headed up the MCH Research Program; both Lamberty, who had been hired by Gershenson in 1967,¹⁰² and Papai had come over with Arthur Lesser from the old Children's Bureau.¹⁰³

^{xv} In 1972, Hutchins became Director of the Division of Research within MCHS; after the 1973 reorganization, he became Director of the DCS, where MCH research was housed.

^{xvi} Five years later in 1987, with BCHS growing in size, Martin recommended that the Division of MCH, then under Vince Hutchins, become a division within a new Bureau--the Bureau of Maternal and Child Health and Resources Development (BMCHRD), under dentist Daniel Whiteside. In 1982, HSA had become HRSA. The Department of Health, Education, and Welfare (HEW) had been renamed the Department of Health and Human Services (HHS) in 1979, when its education functions were transferred to the newly created U.S. Department of Education.

^{xvii} What remained of the original Children's Bureau, along with Head Start, had in the meantime become part of what is now the Administration for Children and Families (ACF) within Health and Human Services. The 1960 child welfare research and demonstration funds, the 1962 child welfare training money, and administration of selected Title IV child welfare services all eventually found their way back into the Children's Bureau within ACF.

In 1994, MCHB convened an advisory group representing the MCH community in order to “reexamine its research agenda and priorities”.^{xviii} The purpose of the ensuing “Title V Maternal and Child Health Research Priorities Conference” was to recommend a research agenda that would “guide the applied MCH research activities for the nation through the year 2000 and beyond”.¹⁰⁴ Kessel stated¹⁰⁵:

“We are asking you to take up the charge, not for the Maternal and Child Health Bureau—the ‘making change happen’ Bureau—but rather, as our mission dictates, for all of America’s children and families. This is the distinctive duality inherent in Title V unique legislation [that] combines management of directly appropriated resources with leadership and advocacy for America’s children and families. Collectively, we have fulfilled these responsibilities . . . for nearly 60 years, as both descendant of and successor to the Children’s Bureau.”

According to Lamberty¹⁰⁶, the research agenda developed by the conference identified four overarching priorities:

“The agenda (1) is equally concerned with the psychosocial and the biological substrates of health and disease; (2) considers social equity in health status, access to health services, and use of health services as an imperative; (3) has a multidimensional and multidisciplinary conception of health and illness; and (4) views the prevailing social stratification system and the ecologies in which parents’ and children’s lives are scripted as powerful determinants of wellbeing or ill health.”

^{xviii} At the time, Audrey Nora was leading MCHB. She took over for Vince Hutchins after he retired in 1992; in 1998, Nora left and Peter van Dyck became head of MCHB, a position he continued in for 13 years until his retirement in the summer of 2011. In January, 2012, Michael Lu became the fifth head of Maternal and Child Health in the PHS, following Lesser, Hutchins, Nora, and van Dyck.

These priorities, although not articulated until 1994, are evident in the research funded by the MCH Research program from the time of the 1969 reorganization onward.^{xix} In the 1970s, '80s, and '90s, some of the notable research studies conducted with funds from the MCH Research Program included:¹⁰⁷

- Jekel and Klerman's research on programs for teen mothers;
- Furstenberg's research on the social consequences of adolescent childbearing;
- Campbell and Ramey's Abecedarian project age-21 follow-up study (with the Department of Education, the David and Lucile Packard Foundation, the Frank Porter Graham Child Development Center);
- Werner's longitudinal research on the children of Kauai;
- Klaus and Kennel's studies on mother-infant bonding;
- Olds' (Elmira) study of the effects of a nurse home visiting program on maternal and child outcomes;
- The Infant Health and Development Program (with NIH and Robert J. Woods Foundation);
- Shonkoff's Early Intervention Collaborative Study, Phase 1;
- Frisancho's research on anthropomorphic standards for the evaluation of growth and nutritional status;
- Newman's study on jaundiced term infants;
- Black's randomized clinical trial of an intervention designed to promote growth and development in low-income children with nonorganic failure to thrive;
- Kotch and Weigle's investigation of fecal contamination in child care centers; and

^{xix} In the early 1990s, a standing scientific review committee was established by the Secretary to provide external scientific peer review of all grant applications submitted for funding to the MCH Research program.

- Rosen's studies on the use of L-line x-ray fluorescence to measure bone lead accumulation in children.

In 1999, the Division of Science, Education, and Analysis (DSEA) was renamed the Division of Research, Training, and Education (DRTE).^{xx} The Research Branch within DRTE was led by Tan Lamberty until his retirement in 2001; in 2005, Stella Yu became Chief of the Research Branch. On March 7, 2012, the MCH Research Program became the Division of Research, headed by Stella Yu, within the Office of Epidemiology and Research in MCHB (headed by Michael Kogan). In the forty-three years following the 1969 reorganization, MCH research had gone from being a program within a Branch, then a Branch within a Division, and was finally a Division within an Office. As with any restructuring, organizational change brings the opportunity for strategic visioning and growth.

The MCH Research Program Today

Today, the Maternal and Child Health (MCH) Extramural Research Program within MCHB supports applied research that has the potential to improve health services and care delivery, and to promote health and wellbeing among MCH populations. In its scope, it: (a) is interdisciplinary; (b) focuses on the health and wellbeing of women, children, and adolescents; (c) examines the social and environmental contexts of health and wellbeing; (d) encourages an integrated view of family health and wellbeing over the lifespan and across generations; (e) explores the interwoven roles of families, schools, neighborhoods, culture, policies, and systems of care; (f) seeks to reduce racial disparities in indices of health and wellbeing; and (g) promotes health and wellbeing through the comprehensive coordination of systems of care across domains

^{xx} DRTE was headed first by Ann Drum, and then beginning in 2009 by Laura Kavanagh, who had been the Training Branch Chief under Drum.

(physical, cognitive, social, and emotional) and settings (families, schools, communities, and agencies).

In terms of strategic goals, the MCH Research Program is closely aligned with its parent agencies, MCHB and HRSA, and as such it seeks to: (a) improve health infrastructure and provision of care by studying service systems at the community, State, and/or national levels, as they apply to different MCH populations; (b) eliminate health disparities by examining barriers to health care access among MCH populations; (c) assure quality of care by investigating the factors that promote quality of health care service delivery; and (d) promote an environment that supports maternal and child health by studying factors that contribute to the health and wellbeing of MCH populations. As part of its mission, it has a particular interest in vulnerable populations, such as mothers, children, and families who are rural or urban; low-income; immigrant; racial and ethnic minorities; high-risk; or medically underserved.

The MCH Research Program funds diverse projects relevant to the health and wellbeing of women, children, and adolescents; the grants, small to medium in size, focus on innovative efforts on topics such as:

- Prenatal Health and Pregnancy Outcomes
- Nutrition, Obesity, and Physical Activity
- Socioemotional Health and Wellbeing
- Parenting and Child Development
- School Outcomes and Services
- Developmental Disabilities
- Promotion of Health and Wellbeing
- Health Care Systems and Delivery

- Oral Health

The funds from the 1963 amendments which authorized the MCH extramural research program are today administered by the MCH Research Program through: (a) its R40 grant mechanism, which funds both multiyear research studies, and one-year secondary analyses of existing datasets such as MCHB's National Survey of Children's Health, and National Survey of Children with Special Health Care Needs;^{xxi} and (b) three Research Networks--Pregnancy Related Care (PRC-RN), Pediatric Research in the Office Setting (PROS), and Life Course (LC-RN). The Research Networks focus on collaborative multisite research and the dissemination of information to researchers, professionals in the field, families, and the public at large.

Besides the extramural research authorized under the 1963 amendments, the MCH Research Program administers projects funded through:

- The Combating Autism Act (2006), including
 - Field-initiated R40 research projects, and
 - Three Research Networks that focus on
 - Autism Intervention Research for Physical Health (AIR-P);
 - Autism Intervention Research for Behavioral Health (AIR-B); and
 - Developmental Behavioral Pediatrics (DBP-Net);
- The Maternal, Infant, and Early Childhood Home Visiting Program (authorized under the Affordable Care Act of 2010)
 - The MCH Research Program is currently initiating a Home Visiting Research Network, as well as field-initiated grants designed to advance Home Visiting research; and

^{xxi} Since the inception of the secondary data analysis (SDAS) research program in 2007, the MCH Research Program has funded over 50 SDAS projects.

- ARRA funding
 - To conduct comparative effectiveness research in pediatric primary care sites around the United States through the use of certified Electronic Health Records (ePROS) to address critical child health issues and generate new knowledge to improve pediatric practice. This effort includes additional collaboration with NICHD to conduct research using the ePROS infrastructure.

Finally, MCH Research today supports a strong communications program of podcasts, videocasts, webinars, research workshops, electronic newsletters, as well as a website with detailed descriptions of all supported projects; these communication efforts are designed to disseminate findings to professionals engaged in MCH-related research and services, as well as to the public.

Concluding Thoughts

Through its 100 year history, the Children’s Bureau—and Maternal and Child Health Research within the Children’s Bureau—has fulfilled its mission to “investigate and report... upon all matters pertaining to the welfare of children and child life among all classes of our people” by focusing on research that:

- Takes a multidisciplinary approach by considering the health and wellbeing of the child as a whole;
- Prioritizes research that seeks to translate and apply knowledge, both through new policies which inform training and clinical practice, as well as through new and innovative interventions which promote health and wellbeing among MCH populations;
- Places the child in socioecological context, and considers the multiple influences on development, health, and wellbeing throughout the life course; and

- Targets underserved and vulnerable populations of mothers, children, and families.

Today, the original mission of the Children’s Bureau continues separately in MCHB (maternal and child health) and ACF (child welfare).^{xxii} Opportunities have occurred over the years for these two agencies within HHS to collaborate and coordinate their efforts in the service of children, most recently in the Maternal, Infant, and Early Childhood Home Visiting program, which was given by Congress in 2010 to HRSA and ACF to administer jointly. In 1967, Martha Eliot lamented that:¹⁰⁸

“To break apart and disperse to other federal agencies the administration of the grants for child welfare services and maternal and child health and crippled children’s services would be to do away with the opportunity that exists day in and day out for frequent discussions—formal and informal—among the Children’s Bureau staff who develop policy and consult with the states as to their programs for children. . . . At this time when pediatric thought and opinion have thus broadened the concept of child health, it would be unfortunate indeed if a reorganization . . . should result in a narrower view with child health responsibilities being assigned to one agency of government and child welfare responsibilities to another. If such reorganization is indeed carried out—a piece of the child here and a piece of the child there—it would greatly weaken the one agency of government, the Children’s Bureau, which . . . the Congress created to concern itself with all aspects of child life. The Children’s Bureau is the agency of government more than any other that has reflected the pediatricians’ concern for all the needs of ‘the whole child’. The broad point of view must prevail and the bureau’s role strengthened in behalf

^{xxii} Other Departments, such as Labor and Justice, also continue specific efforts spearheaded by the Children’s Bureau.

of children—all children. . . . strengthened by adding to it or associating closely with it other federal programs contributing to the betterment of child life.”

In 2012, the complexities of specialized training, knowledge, and professional and public constituencies are such that it seems unlikely that any single agency could ever again administer all the programs that the original Children’s Bureau once handled. However, just as in child-related fields more generally, breaking across individual silos and thinking once again of the needs of “the whole child” could provide impetus for innovative efforts in the future.

Imbued with the spirit and passion of the first five Chiefs, MCH Research has sought to ensure not only that all people are born equal, but that they should receive the nurturing opportunities necessary to become equal citizens.¹⁰⁹ This passion is expressed by second Chief of the Bureau Grace Abbott, who describes a symbolic traffic jam of vehicles, representing all the great concerns of the country, jostling their way up the avenue to Capitol Hill in search of direction and solutions. In the traffic jam, tanks pull into the road, symbolizing the needs of the Army; plows appear representing the concerns of agriculture, and so on. In the midst of this great traffic jam, watching the road become increasingly congested and difficult, Abbott says: “Then because the responsibility is mine and I must, I take a very firm hold on the handles of the baby carriage and I wheel it into the traffic.”¹¹⁰ The MCH Research Program, beginning in 1912 in the original Children’s Bureau and continuing on through its transfer to what is now HRSA, has for 100 years provided leadership in promoting health and wellbeing among mothers, children, and families in the U.S. As Katherine Oettinger stated in 1962:¹¹¹

“The Bureau's past has truly been a prologue, and what the future will bring for children is not clearly outlined today. One certainty is clear--children will be a major concern of our democratic society and government. Citizens, Federal, State, and local public and

voluntary organizations will continue to join forces to advance the one sure resource of the future, the Nation's children.”

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